

	SOLICITATION AMENDMENT Solicitation Number: <u>RFP YH04-0001</u> Amendment Number One Solicitation Due Date: March 31, 2003, 3:00 PM (MST)	Arizona Health Care Cost Containment System Administration (AHCCCSA) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Michael Veit, (602) 417-4762
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A signed copy of this amendment must be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:

1. **REMOVE AND REPLACE:** REMOVE page 58 and REPLACE with the attached Revised Page 58, dated February 10, 2003.
2. **REMOVE AND REPLACE:** REMOVE page 99 and REPLACE with the attached Revised Page 99, dated February 10, 2003.
3. **REMOVE AND REPLACE:** REMOVE all pages under Tab "B, "Program Changes", and REPLACE with the attached four (4) revised pages of the DATA SUPPLEMENT, dated February 10, 2003.
4. **REMOVE AND REPLACE:** REMOVE the first sheet under Tab "T, "Reinsurance Payments CYE 19 (2001)" and REPLACE with the attached revised page of the DATA SUPPLEMENT, dated February 10, 2003.
5. All other terms and conditions remains the same, including the proposal due date and time.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this 10th day of February, 2003, in Phoenix, Arizona.	
Signature	Date		
		Signed Copy in File	
Typed Name and Title		Michael Veit	
		Contracts and Purchasing Administrator	
Name of Company			

Incentive Fund: AHCCCSA may retain a specified percentage of capitation reimbursement in order to distribute to Contractors based on their performance measure outcomes. The incentive fund will not be implemented in CYE '04 and contractors will be notified at least 60 days prior to implementation in a future contract year.

58. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCSA to the Contractor for the partial reimbursement of covered services, as described below, for a member with an acute medical condition beyond an annual deductible level. AHCCCSA "self-insures" the reinsurance program through a deduction to capitation rates that is intended to be budget neutral. Refer to the *AHCCCSA Reinsurance Claims Processing Manual* for further details on the Reinsurance Program.

Inpatient Reinsurance

Inpatient reinsurance covers partial reimbursement of covered inpatient facility medical services. See the table below for applicable deductible levels and coinsurance percentages. The coinsurance percent is the rate at which AHCCCSA will reimburse the Contractor for covered inpatient services incurred above the deductible. The deductible is the responsibility of the Contractor. Per diem rates paid for nursing facility services provided within 30 days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any contract year shall be eligible for reinsurance coverage.

The following table represents deductible and coinsurance levels for CYE '04:

<i>Statewide Plan Enrollment</i>	<i>Annual Deductible*</i>	<i>Title XIX Waiver Group Annual Deductible</i>	<i>Coinsurance</i>
	<i>Prospective Reinsurance</i>	<i>Combined PPC and Prospective Reinsurance</i>	
0-34,999	\$20,000	\$15,000	75%
35,000-49,999	\$35,000	\$15,000	75%
50,000 and over	\$50,000	\$15,000	75%

*applies to all members except for Title XIX Waiver Group members

a) Prospective Reinsurance: This coverage applies to prospective enrollment periods. The deductible level is based on the Contractor's statewide AHCCCS acute care enrollment (not including SOBRA Family Planning Extension services) as of October 1st each contract year for all rate codes and counties, as shown in the table above. AHCCCSA will adjust the Contractor's deductible level at the beginning of a contract year if the Contractor's enrollment changes to the next enrollment level. A Contractor at the \$35,000 or \$50,000 deductible level may elect a lower deductible prior to the beginning of a new contract year. These deductible levels are subject to change by AHCCCSA during the term of this contract. Any change will have a corresponding impact on capitation rates.

b) Prior Period Coverage Reinsurance: Effective October 1, 2003, AHCCCSA will no longer cover PPC inpatient expenses under the reinsurance program for any members except Title XIX Waiver Group members. See section c) below for additional information.

Capacity Analysis/Planning and Development

8. Provide a copy of the Offeror's Network Development and Management Plan. (No page limit)
Reference: Section D, Paragraph 27, Network Development (Provider Network Development and Management Plan)
9. Provide a synopsis of the Offeror's Disaster Recovery Plan as it relates to the provider network. (No page limit)
Reference: Section D, Paragraph 73, Business Continuity Plan

III. Capitation

Capitation is a fixed (per member) monthly payment to contractors for the provision of covered services to members. It is an actuarially sound amount to cover expected utilization and costs for the individual risk groups in a risk-sharing managed care environment. The Offeror must demonstrate that the capitation rates proposed are actuarially sound. In general terms, this means that the Offeror who is awarded a contract should be able to keep utilization at or near its proposed levels and that it will be able to contract for unit costs that average at or near the amounts shown on the Capitation Rates Calculation Sheet (CRCS). This requirement also applies to bids submitted in best and final offer rounds.

Prior Period Coverage (PPC) and HIV/AIDS Supplement rates will be set by AHCCCS' actuaries and not bid by the Contractor. Due to the lack of complete historical data, the Title XIX Waiver Group and HIFA Parents' rates will also be set by AHCCCS' actuaries, rather than bid by the Contractor. See Section D, Paragraph 53, Compensation, for information regarding risk sharing for the Title XIX Waiver Group and PPC time period. All other rate codes, including the Delivery Supplemental Payment, will be subject to competitive bidding.

To facilitate the preparation of its capitation proposals, AHCCCSA will provide each Offeror with a Data Supplement. This data source should not be used as the sole source of information in making decisions concerning the capitation proposal. Each Offeror is solely responsible for research, preparation and documentation of its capitation proposal.

Required Submission: Capitation

10. The Offeror must submit its capitation proposal using the AHCCCSA bid web site. Instructions for accessing and using the web site will be issued by March 1, 2003. The Offeror must have an actuary who is a member of the American Academy of Actuaries certify that the bid submission is actuarially sound. This certification must be done with subsequent submissions in Best and Final Offer rounds (if applicable). The Offeror must also submit hard copy print outs of the web site CRCS. Refer to Section B and Attachment E for more details.

The Offeror must prepare and submit its capitation proposal assuming a \$20,000 deductible level for regular reinsurance, for all rate codes, in all counties. AHCCCSA will provide a table of per member per month reinsurance adjustments to be made to capitation rates for those Contractors whose actual deductible level exceeds \$20,000.

Capitation rates shall be submitted two ways: first, assuming all medical services are included in the capitation rates, and second, assuming that prescription drugs will be carved out of the capitation rates. Prescription drugs are defined as "FDA approved legend or over the counter (OTC) products provided upon receipt of a valid prescription order and dispensed by a pharmacist in an outpatient setting." When bidding with prescription drugs carved out, please factor the impact to the other medical service and administrative categories. AHCCCSA anticipates that in the event that prescription drugs are carved

PROGRAM CHANGES

The following program changes should be considered when reviewing the Encounter Utilization Reports and financial information provided in the data supplement for preparation of the capitation rate bid submissions. There are also program changes that are not included in this data supplement. These changes are either effective after the time period for which encounters and claims have been gathered, or will be effective on or after October 1, 2003. Below is a brief description of the AHCCCS acute program changes and their effective dates:

Geographic Service Areas

AHCCCSA has regrouped Arizona counties into the following GSA's:

Geographic Service Area (GSA)	Maximum Number of Contracts
2. Yuma, La Paz	2
4. Mohave, Coconino, Apache, Navajo	2
6. Yavapai	2
8. Pinal, Gila	2
10. Pima, Santa Cruz	5/2
12. Maricopa	6
14. Graham, Greenlee, Cochise	2

Contracts will be awarded by GSA. For GSA #10, up to five contracts will be awarded for Pima County, and up to two of those five contracts will include an award for Santa Cruz County.

The data supplement information has been revised to regroup counties into the GSA's proposed for October 1, 2003.

2nd Newborn Screen (PKU) Testing

Effective February 1, 2002, the Arizona Department of Health Services (ADHS) requires that a 2nd Newborn Screen test be done on all Arizona Newborns. The code for the testing is S3620. The cost of the test is \$20. In addition to the cost of the test, there are associated handling fees that Contractors are required to pay to the providers collecting the test. The AHCCCS fee for service schedule for handling fees is \$4.25 for tests performed in physicians' offices, and \$10.00 for tests performed in

contracted laboratory facilities. These services are not included in the data supplement due to lag in capturing encounter data.

Circumcisions

Effective October 1, 2002 elective circumcisions are no longer a covered service. Circumcision services have been removed from the Encounter Utilization Reports.

Hospital Pilot Program

The hospital pilot program in Maricopa and Pima counties was terminated for CYE '01 and reinstated for CYE '02 and CYE '03. The pilot program states that if a health plan in Maricopa and Pima counties is unable to contract with a hospital for inpatient services, then the health plan reimbursement rate is 95% of the AHCCCS Tier Per Diems. Health plan cost information for inpatient stays in Maricopa and Pima counties will reflect the termination of the pilot program for CYE '01. Even though the program is scheduled to be terminated for CYE '04, bidders should assume that the pilot program will be reinstated through legislation.

Title XIX Waiver Group

Effective April 1, 2001, AHCCCS received a waiver from CMS that converted the Medically Needy/Medically Indigent (MNMI) population from a state funded only population to a Title XIX funded population. This group was renamed the Title XIX Waiver Group (TWG).

This population has two components. First, effective October 1, 2001, the eligibility criteria changed to increase the Federal Poverty Level (FPL) for determining Title XIX eligibility to incomes at or below 100% of the FPL (non-MED's) from 40% of the FPL. The second group of members is the Medical Expense Deduction (MED). These members have incomes above 100% of the FPL, but incur sufficient medical costs that cause them to "spend down" to below 40% of the FPL.

Due to the historical high percentage of MNMI members becoming eligible while hospitalized, AHCCCSA created a hospitalized supplemental payment as a method of risk adjustment for this population. After monitoring the actual percentages of members who become eligible while hospitalized, effective October 1, 2003, AHCCCSA will no longer pay a hospitalized supplement for the non-MED portion of the Title XIX Waiver Group.

Due to uncertainty of the risk of this population, AHCCCSA will continue to set the capitation rates and reconcile the medical expenditures for CYE '04. The reconciliation will include a 2% risk band. Refer to the *Title XIX Waiver Group Reconciliation Policy* in the Bidder's Library for more details.

Prior Period Coverage

For CYE '03, AHCCCS placed health plans at full risk for medical service expenditures incurred during the Prior Period Coverage (PPC) time period. There will *not* be a reconciliation for CYE '03 PPC expenditures.

Effective CYE '04, AHCCCS will set the capitation rates for the PPC time period and reconcile PPC medical expenses to service revenues per the *PPC Reconciliation Policy* found in the bidder's library. The reconciliation will include a 2% risk band.

Breast and Cervical Cancer Treatment Program

Effective January 1, 2002, AHCCCS implemented the Breast and Cervical Cancer Treatment Program. For CYE '02, all medical costs associated with this population were paid through the AHCCCS reinsurance program. In addition, health plans were paid the TANF 14-44F capitation rate on a monthly basis. For years beginning with CYE '04, the plans will be at full risk for this population. AHCCCSA will no longer pay for medical services through reinsurance. The encounter utilization reports for CYE '02 include the rate codes and medical experience for the BCCTP population in the TANF 14-44F and TANF 45+ risk groups.

HIFA Parents

Effective January 1, 2003, AHCCCSA implemented its HIFA waiver with CMS that permits using excess Title XXI funds to cover the parents of KidsCare and SOBRA Children eligible members who are not otherwise eligible. This program has a limit on the enrollment due to the availability of excess funding. Because there are currently no encounters for this population, AHCCCSA will set the rates for CYE '04.

KidsCare/TANF (1931) Combining

Effective October 1, 2002, AHCCCSA blended the cost and utilization experience of the health plans for the purpose of establishing one capitation rate for TANF (1931)/ SOBRA/ and KidsCare members. The

Encounter Utilization Reports have been restated to include the KidsCare rate codes in the TANF/SOBRA risk groups.

Population Growth

With the passage of Proposition 204 in October 2001 that increased the Medicaid eligibility level to 100% of the FPL, AHCCCS population has grown dramatically. In addition to Proposition 204, AHCCCS' membership has grown due to the downturn in the economy as well as new efficiencies in the eligibility process. This growth is represented in member month and enrollment information presented in this supplement.

Reinsurance Payments for CYE '01

This section presents the statewide reinsurance paid per member per month to health plans for the period October 1, 2000 through September 30, 2001. When estimating reinsurance, the bidder should consider all changes to the reinsurance program effective October 1, 2003. The bidder should also consider changes in rates and utilization from year to year.

See Section B, Program Changes, for reinsurance deductible level changes effective October 1, 2003. The bidder should note that all bids should be prepared assuming the deductible levels for statewide enrollment of 0-35,000 members (\$20,000). If the health plan's statewide enrollment exceeds 35,000 members, their capitation rates will be adjusted upwards where applicable, to offset the higher deductible levels.